Jeffrey F. Olliffe, M.D.
1817 12th Avenue, Seattle, WA 98122

REGISTRATION FORM

_____
Date

_____ _____ _____
Patient Last Name **First Name** **M.I.**

_____ _____ _____ _____
Street Address **City** **State** **ZIP**

(_____)_____ (_____)_____ (_____)_____ **CIRCLE #'s WHERE DETAILED**
Home Phone # **Work Phone # & Ext.** **Cell Phone #** **MESSAGES MAY BE LEFT**

____/____/_____ _____ _____/_____/_____ _____
Date of Birth **Sex** **Social Security Number** **E-MAIL Address**

_____ _____
Patient Employer **Employer Address**

_____ _____
Relationship Status **Partner/Spouse Name**
(single, married, coupled, etc)

_____ (_____)_____ _____
EMERGENCY CONTACT NAME **PHONE NUMBER** **RELATION TO PATIENT**

INSURANCE INFORMATION:

_____
Subscriber Name

_____ _____
Insurance Company Name **Mailing Address**

_____ _____ (_____)_____
ID/Subscriber Number **Group Number** **Telephone Number**

Assignment of Benefits and Release: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for claim submission.

_____
SIGNATURE

GUARANTOR/RESPONSIBLE PARTY (IF UNDER 18 YEARS OLD):

_____

NAME

_____

ADDRESS

(_____)_____ (_____)_____

PHONE NUMBER **WORK PHONE NUMBER**

_____

EMPLOYER

_____

EMPLOYER ADDRESS

_____

RELATION TO PATIENT

_____

E-MAIL ADDRESS

PERSONAL MEDICAL HISTORY:

Major Illnesses, Operations, Accidents, Hospitalizations, and Dates:

_____

_____

Medication Currently Used and Dosages (including vitamin/mineral/herbal supplements):

_____

_____

_____

Allergies:

_____

_____

DO YOU SMOKE CIGARETTES? _____

DO YOU EXERCISE REGULARLY? _____

DO YOU DRINK ALCOHOL? _____

HOW MANY DRINKS PER WEEK? _____

DO YOU USE RECREATIONAL DRUGS? _____

SOCIAL AND FAMILY HISTORY:

Number of siblings? _____

Number of children? _____

Father: age if living? _____ **age at death?** _____

Mother: age if living? _____ **age at death?** _____

Number of persons living in your home? _____

HAS ANYONE IN YOUR FAMILY HAD:

DIABETES? _____

HEART DISEASE? _____

HIGH BLOOD PRESSURE? _____

TUBERCULOSIS? _____

BREAST CANCER? _____

COLON CANCER? _____

ALCOHOLISM? _____

SUICIDE? _____